The application must be completed in its entirety and submitted with all required documentation and fees. Incomplete submissions will be rejected.

PROGRAM INFORMATION

The following must be included with each application:

- Check or money order made payable to West Virginia Department of Health and Human Resources (WVDHHR) for a non-refundable license fee.
- Verification of education and training for all physicians practicing at the program such as fellowships, additional education, accreditations, board certifications and other certifications.
- Board of Pharmacy Controlled Substance Prescriber Report for each prescriber practicing at the program for the three months preceding the application.
- Medical Director must demonstrate experience in substance use disorder treatment or medication-assisted treatment or have a written plan, not to exceed 12 months, to attain competence.
- Program physicians and physician extenders must provide the following:
  - Minimum of 1 year experience in substance use disorder treatment and medication-assisted treatment settings; OR
  - Active enrollment in a plan of education for obtaining competence approved by the medical director – and – completion of certification, training programs or continuing education programs recommended and approved by the medical director of program.
- Program Sponsor provide documentation of the following:
  - All current federal accreditations, certifications and authorizations.
- Program Administrator must provide documentation of the following:
  - All current federal accreditations, certifications and authorizations.
  - Minimum requirements:
    - Bachelor's degree in appropriate area of study and minimum of 4 years of experience in fields of substance use disorders, behavioral health or health care administration; OR
    - Master's degree in appropriate professional area of study and a minimum of 2 years of experience in the fields of substance abuse disorders, behavioral health or health care administration; OR
    - Eight years of experience in fields of substance use disorders, behavioral health administration or health care administration
- Counseling staff must provide a listing of qualifications and current trainings and accreditations for each counselor:
  - The listing may be submitted as an addendum included with the application; and
  - Supporting documentation must be readily available at the time of survey.
- Documentation of all current federal accreditations, certifications and authorizations of the program.
- Programs not in existence as of September 14, 2016 must submit a letter from the State Opioid Treatment Authority granting authority for a medication-assisted treatment program in this state.
- If applicable, a copy of a valid Certificate of Need or a letter of exemption from the West Virginia Health Care Authority must be included.

GENERAL INSTRUCTIONS

Program Information

- **Operating Name** – The full operating name of the program, as advertised
- **Legal Name** – The legal name of the program, as registered with the West Virginia Secretary State
- **Physical Address** – The physical location of the program
- **Mailing Address** – The preferred mailing address for the program
- **Email Address** – The address to be used as the primary contact for the program

Business Information

- **FEIN Number** – Federal Employer Identification Number assigned to program
- **Licenses** – List all business licenses issued to the program by this state, the state tax department, Secretary of State and all other applicable business entities
- **Description of Services** – Brief description of all services provided by the program
- **Hours of Operation** – Days and times the program is open for services

Owner Information

- **Legal Registered Owner Name** – Name of the person registered as the legal owner of the clinic. If more than one legal owner (i.e. partnership), use the application appendix and list each legal owner separate, including percentage of ownership.

Medical Director

- **Full Name –** Full name of person working in the capacity of the Medical Director
- **Medical License # -** Current West Virginia Medical License number
- **DEA# -** Current DEA Registration number. Also provide current DEA # for prescribing buprenorphine, if applicable.
- **Current Certifications –** All current certifications held
- **Verifiable hours worked at the program per week** – The number of hours the Medical Director works at the program per week

Program Sponsor

- **Full Name -** Full name of person working in the capacity of Program Sponsor
- **Occupation/Position –** The professional occupation of the Program Sponsor
- **Verifiable hours worked at the program per week –** The number of hours the Program Sponsor works at the program per week
- **Medical License # -** Current West Virginia Medical License number, if applicable.
- **DEA# -** Current DEA Registration number, if applicable. Also provide DEA # for prescribing buprenorphine, if applicable.
- **Education –** Listing of education, qualifications and accreditations meeting the requirements of the position of Program Sponsor.

Program Administrator

- **Full Name -** Full name of personnel employed by the program
- **Occupation/Position –** The professional occupation of the Program Administrator
- **Verifiable hours worked at the program per week –** The number of hours the Program Administrator works at the program per week
- **Medical License # -** Current West Virginia Medical License number, if applicable.

- **DEA# -** Current DEA Registration number, if applicable. Also provide DEA # for prescribing buprenorphine, if applicable.
- **Education –** Listing of education, qualifications and accreditations meeting the requirements of the position of Program Administrator.

Personnel Information – Must include all management staff, including clinical, not otherwise listed

- **Full Name -** Full name of personnel employed by the program
- **Occupation/Position –** The professional occupation of each individual person and the position each individual holds in the program
- **Verifiable hours worked at the program per week –** The number of hours each person works in the program.
- **Medical License # -** Current West Virginia Medical License number, if applicable.
- **DEA# -** Current DEA Registration number, if applicable. Also provide DEA # for prescribing buprenorphine, if applicable.

Other Program Owned or Operated by Applicant

- List any other program owned or operated by applicant, including location address. **All locations must be licensed separately.**

Description of Organizational Structure of Program

- List all owners, medical directors, program administrators, physicians, physician extenders, nursing staff, counseling staff, and other management staff, their positions and how those positions are represented in the organizational structure of the program.
- An organizational chart, including names and positions, may be attached to address this question.

Disclaimer and Signature

- The application must be signed by the Program Sponsor in the presence of a Notary Public of the State of West Virginia.

Office of Health Facility Licensure & Certification

OPIOID TREATMENT PROGRAM INITIAL / RENEWAL LICENSURE APPLICATION

COMPLETE THIS APPLICATION AND RETURN TO:

Office of Health Facility Licensure & Certification
Attention: Medication-Assisted Treatment Program
408 Leon Sullivan Way
Charleston, WV 25301-1713
(304) 558-0050

LOG NUMBER _____

DATE _____

OFFICIAL USE ONLY

NOTE: This application can only be accepted if all required fields are completed and additional requested documentation is attached.

PROGRAM INFORMATION

Operating Name of the Program: _____

Legal Name of the Program[1] _____

Physical Address: _____
Street Address

_____
City *State* *ZIP Code*

Mailing Address: _____
Street Address

_____
City *State* *ZIP Code*

Phone: ( ) _____ **Fax:** ( ) _____

E-mail Address: _____

Website URL: _____

BUSINESS INFORMATION

FEIN: _____

Licenses:[2] _____

_____

Description of Services: _____

_____

_____

_____

[1] As registered with the WV Secretary of State.
[2] All business licenses issued to the program by the WV State Tax Department, WV Secretary of State and all other applicable business entities.

Hours of Operation: (specifically designating hours in which medication is being administered)	Sun	Mon	Tue	Wed	Thurs	Fri	Sat

PROGRAM INFORMATION

Exact Legal Name of Program Owner:[3] _____

Mailing Address: _____

Street Address

_____

City *State* *ZIP Code*

Phone: ( ) _____ **Fax:** ( ) _____

E-mail Address: _____

Percentage of ownership: _____

MEDICAL DIRECTOR[4]

Full Name: _____

Last *First* *M.I.*

Medical License #: _____ **DEA #:** _____

DEA # to prescribe buprenorphine addiction (if applicable): _____

Current Certifications: _____

Verifiable hours worked at program per week: _____

Full Name: _____

Last *First* *M.I.*

Medical License #: _____ **DEA #:** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Current Certifications: _____

Verifiable hours worked at program per week: _____

[3] If more than one legal owner – list each legal owner separately, indicating percentage of ownership.
[4] If more than one Medical Director – provide all information for each and every medical director.

PROGRAM SPONSOR

Full Name: _____
Last *First* *M.I.*

Occupation and Position: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Education: _____

PROGRAM ADMINISTRATOR

Full Name: _____
Last *First* *M.I.*

Occupation and Position: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Education: _____

PERSONNEL INFORMATION

Full Name: _____
Last *First* *M.I.*

Occupation and Position: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Full Name: _____
Last *First* *M.I.*

Occupation: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____
DEA # to prescribe buprenorphine foraddiction (if applicable): _____

Full Name: ______________________________

Last *First* *M.I.*

Occupation: ______________ **Verifiable hours worked at program per week:** ______________

License # (if applicable): ______________ **DEA # (if applicable):** ______________

DEA # to prescribe buprenorphine for addiction (if applicable): ______________________________

Full Name: ______________________________

Last *First* *M.I.*

Occupation: ______________ **Verifiable hours worked at program per week:** ______________

License # (if applicable): ______________ **DEA # (if applicable):** ______________

DEA # to prescribe buprenorphine for addiction (if applicable): ______________________________

Full Name: ______________________________

Last *First* *M.I.*

Occupation: ______________ **Verifiable hours worked at program per week:** ______________

License # (if applicable): ______________ **DEA # (if applicable):** ______________

DEA # to prescribe buprenorphine for addiction (if applicable): ______________________________

OTHER PROGRAM OWNED OR OPERATED BY APPLICANT

Operating Name: ______________________________

Address: ______________________________

Street Address

____

City *State* *ZIP Code*

OTHER PROGRAM OWNED OR OPERATED BY APPLICANT

Operating Name: ______________________________

Address: ______________________________

Street Address

____

City *State* *ZIP Code*

DESCRIPTION OF ORGANIZATIONAL STRUCTURE OF THE PROGRAM
*DETAIL THE ORGANIZATIONAL STRUCTURE OF THE PROGRAM (E.G., ORGANIZATIONAL CHART).

DISCLAIMER

By signing this application I hereby verify that no owner or operator applying for this license has been the owner or operator of a medication-assisted treatment program that has had its license or registration suspended or revoked in the five (5) years preceding the date of this application. I further verify that a criminal records background check has been completed, pursuant to W.Va. Code § 16-5Y-5(h), for each anticipated owner, physician, counseling staff, employee, volunteer, associated or contracted agent.

SIGNATURE

Signature of Program Sponsor: _____

STATE OF WEST VIRGINIA
County of _____

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof: that the statements concerning the above named Center/Agency, therein contained, are correct and true of his/her own knowledge.

Subscribed and sworn to before me this_____ day of _____, 20_____.

_____
Notary Public

My Commission Expires: _____

PERSONNEL ADDENDUM – IF NEEDED

PERSONNEL INFORMATION

Full Name: _____
Last *First* *M.I.*

Occupation and Position: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Full Name: _____
Last *First* *M.I.*

Occupation: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____

Full Name: _____
Last *First* *M.I.*

Occupation: _____ **Verifiable hours worked at program per week:** _____

License # (if applicable): _____ **DEA # (if applicable):** _____

DEA # to prescribe buprenorphine for addiction (if applicable): _____